IDAHO DEPARTMENT OF
HEALTH & WELFARE

File copy

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

December 22, 2009

Susan Broetje
Idaho State School And Hospital
1660 Eleventh Avenue North
Nampa, ID 83687

Provider #13G001

Dear Ms. Broetje:

On **December 17, 2009**, a complaint survey was conducted at Idaho State School And Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004447

Allegation #1: Individuals are working with other individuals who engage in sexual misconduct without appropriate supervision.

Findings: An unannounced onsite complaint investigation was conducted from 12/14/09 - 12/17/09. During that time, review of investigations, observations, record review, and individual and staff interviews were conducted with the following results:

Observations were conducted throughout the day on 12/14/09 and 12/15/09 for a cumulative 13 hours 25 minutes. During that time, sufficient numbers of direct care staff were noted to present and supervising individuals. Individuals requiring one to one supervision were noted to be supervised in accordance with their program plans. No individuals were noted to engage in sexual misconduct.

During the course of the survey, 34 direct care staff were interviewed about individuals' maladaptive behavior and supervision needs. All staff were able to report individuals' behavioral needs and their supervision requirements based on those needs. Ten individuals (10) were interviewed and all individuals reported staff supervision was adequate and they felt safe.

Twelve (12) individuals' records were reviewed. The individuals' records contained program plans related to their maladaptive behavior as well as plans to address their supervision needs based on their maladaptive behavior.

Additionally, 47 investigations, dated 10/1/09 - 12/14/09, were reviewed. None of the investigations showed sexual misconduct occurred due to a lack of staff supervision.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Guardians are not promptly notified of significant events.

Findings: An unannounced onsite complaint investigation was conducted from 12/14/09 - 12/17/09. During that time, the facility's investigations were reviewed with the following results:

Forty seven (47) investigations were reviewed. Of those, only 1 investigation showed the individual's guardian was notified two days after the incident was identified. The investigation showed the Qualified Mental Retardation Professional (QMRP) identified the failure to notify the guardian and took appropriate corrective action.

Therefore, because there was no systematic pattern of late notification, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw